Case study: Islington's journey: Collaborative care

Background

Islington is the 14th most deprived borough in England. 13% of the borough's population (28,000 people) live with one or more long term conditions. Islington has taken a number of steps to support patients to take an active role in their care.

Islington's journey

- **2006**: **Self-management strategy** produced by Islington PCT.
- **2007-2012**: **Co-creating Health programme** (Health Foundation pilot site). The aim was to bring about a fundamental change in local diabetes care. This involved:
    - ***A Self Management Programme*** to empower diabetes patients with skills, knowledge and confidence
    - ***Advanced Development Programme*** for clinicians
    - ***Service Improvement Programme*** to resign services to better support self-management.
    - The programme has continued as the Self management programme delivered by Whittington Health (includes EPP)

Impact:
- 260 people with diabetes completed the Self Management Programme – the evaluation found that it had helped with problem solving, goal setting, peer support and understanding their conditions. Audits of blood tests before and over one year after attending showed significant improvements in HbA1c for people who attended a SMP.
- 12 local patients and clinicians were **trained to deliver** the programme.
- 148 local clinicians **completed the ADP courses** and **91%** said they had implemented parts of it into their professional practice.

- **2013 – Year of Care for diabetes**
    - Recognition that Islington still needed to improve
    - They held co-creation workshops with patients, clinicians to identify outcomes
    - The CCG began to commission services that would help to meet these.

- **Now** – one of 14 **national integrated care and support pioneers** – priority in 5 year CCG plan to focus on self-care, personalisation, patient activation and mobilisation of community assets.
    - More outreach and co-production activities to consider different approaches
    - Developing the market – ensure commission services that people want
    - Evaluating all the different programmes.

Patient Activation: In October 2014 – Islington started to collect Patient Activation measure (PAM) scores for all patients registered with at LTC. This is a validated tool – to link patients skills, knowledge and confidence, subsequent behaviour and need for support to achieve better outcomes. It is used before and after patient education and support programmes.

The aim of using PAM is help inform self-management commissioning decisions in Islington - to assess the impact of initiatives across the borough, support targeted use of resources, and embed the score in CCG's risk stratification.

House of Care:

Islington have used the House of Care as a framework to guide their integration work – collaborative care support and planning is at the centre, and it structures how health communities and teams work together to achieve this. The separate handout shows what Islington put into their House of Care, and the challenges that remain.

Outcomes so far:

- 2967 self-management plans in places for people with COPD – 82% of the patient cohort
- 3574 care plans reviewed for people with diabetes
- Increased referrals to self-management support programmes.
- Longer appointments – better conversations in primary care
- Good collaborative working across the area

Islington Health Navigators (with Age UK)

Islington found that patients were identifying goals with GPs, but there was a lack of services to support these. They recognised the need to commission VCS organisations. Age UK won the contract fir health navigators - to help improve patient quality of life and maintain independence, in turn delaying the need for more intensive health and social care services. The navigators have been commissioned to use the Patient Activation Measure tool.

GPs can refer patients to health navigators identifying those at medium risk of requiring hospital or specialist care. The service is open weekdays throughout the year and Navigators work closely with a range of statutory and voluntary services to offer patients support in the form of meals and social clubs, mental health services, day and drop in centres, community events. Using deep listening exercises the health navigators develop an understanding of the support that is needed and signpost patients to an appropriate source. Where appropriate they also act as case manager. There are two Locality Navigators, each responsible for a specific geographical area. As well as working with individual patients to connect them with appropriate support to achieve personal health improvement goals they enhance signposting of local services to promote patient's independence in finding support.

The Health Navigator programme is believed to be very successful (and was nominated for an NHS Excellence in Participation Award). There is no formal evaluation at the moment. The CCG now faces the challenge of how to 'up-scale' this activity, one option being to form an umbrella organisation that brings together other health voluntary and community services

Learning points

- It takes **time and resources**
- Need for **strong clinical leadership** at executive and clinical level to change systems and cultures
- Need for **flexibility of delivery** models
- **Integrate concurrent initiatives** - putting self management at the heart of Islington's integration work increased its profile
- Working from the **ground up** – co-production workshops meant all the relevant people were in the same room.
- Year of Care steering group – having **commissioners and providers in the same room** is important.
- Recognising that the journey people are on is not linear – approach is '*what can we do to help take people on that journey*' through shared agenda setting, collaborative goal setting, timely follow up.
- Belief!

Discussion points:

- Has your CCG been on a similar journey?
- What resonates with you from this example?
- Have you experienced these challenges?
- How can you support system wide implementation of self management support in a fragmented commissioning system?
- What are the next steps for your CCG?

"Across the country colleagues are embarking on similar projects based on the evidence that shows what a difference person centred care makes to people's lives… The challenge for commissioners is to respond to this and work with colleagues inside and outside of NHS structures to move person centred care in to the mainstream of healthcare provision." **Dr Katie Coleman, joint Vice Chair of Islington CCG**